



MANUAL HHSC Uniform Managed Care Manual	CHAPTER 16.2	PAGE 1 of 60
CHAPTER TITLE STAR Health Medically Dependent Children Program (MDCP)	EFFECTIVE DATE December 10, 2016 Version 2.0	

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MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	2 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

Table of Contents

I. APPLICABILITY OF CHAPTER 16.2	3
II. PURPOSE AND BACKGROUND	3
III. MDCP OVERVIEW AND ELIGIBILITY	3
IV. SERVICE DELIVERY OPTIONS	23
V. INTAKE AND INITIAL APPLICATION	30
VI. SCREENING, ASSESSMENT, AND SERVICE PLANNING	43
VII. DENIALS AND TERMINATIONS	57



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	3 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

I. APPLICABILITY OF CHAPTER 16.2

This chapter applies to the Managed Care Organization (MCO) administering the STAR Health Program.

II. PURPOSE AND BACKGROUND

This chapter provides processes and procedures and MCO requirements for the administration of the Medically Dependent Children Program (MDCP) to qualified Members enrolled in the STAR Health Program.

MDCP is a Home and Community Based Services (HCBS) program authorized under §1915(c) of the Social Security Act. MDCP provides Respite, flexible family support services (FFSS), Minor Home Modifications, adaptive aids, transition assistance services (TAS), Employment Assistance (EA), Supported Employment, and Financial Management services (FMS) delivered through the STAR Health MCO.

III. MDCP OVERVIEW AND ELIGIBILITY

A. Program Goal

The goal of MDCP is to support families caring for children and young adults age 20 and younger who are medically fragile with a complex need, and to encourage de-institutionalization of children and young adults who reside in nursing facilities (NF). MDCP accomplishes this goal by:

- enabling children and young adults who are medically dependent to remain safely in their homes;
- offering cost-effective alternatives to placement in NFs and hospitals; and
- supporting families in their role as the Caregiver for children and young adults who are medically dependent.

B. MDCP Services



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	4 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

STAR Health Members enrolled in MDCP are eligible for additional services through the MCO as a cost-effective alternative to living in a NF. Receipt of MDCP services does not impact a Member's eligibility for other Long Term Services and Supports (LTSS) available in STAR Health.

42 C.F.R. §441.301(b)(1)(ii) requires that MDCP services may not be provided to a Member who is admitted to a hospital or is a resident of a NF or ICF/IID.

The following sections provide detail about services available to MDCP recipients.

i. Adaptive Aids

Adaptive aids are needed in order to treat, rehabilitate, prevent, or compensate for a condition that results in a disability or a loss of function and helps a Member perform activities of daily living (ADLs) or control the environment in which he or she lives. A Member must exhaust any applicable Medicaid, Medicare, or other third-party resources for durable medical equipment (DME) and adaptive aids before MDCP waiver-funded adaptive aids are authorized. A Member may take an adaptive aid to an out-of-home Respite facility for his or her use while residing there.

The service limit on all adaptive aids combined is \$4,000 per annual Individual Service Plan (ISP) period. The amount paid for an adaptive aid must be documented and retained in the Member's file. After any applicable state plan benefits (e.g., DME) are exhausted, adaptive aids covered in the MDCP include:

- van lifts and other vehicle modifications;
- jump seats;
- tumble form chairs;
- feeder seats;
- medically appropriate strollers;
- barrier-free lifts and stair lifts;
- environmental control units;
- alarm systems;
- support rails;
- electrical work related to use of authorized adaptive aids; and
- installation of and repair to authorized adaptive aids.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	5 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

The MCO may authorize bids for adaptive aids, such as vehicle modifications, as applicable. The cost of these bids do not count against the Member's annual limit for adaptive aids.

If the cost of a requested adaptive aid exceeds the service limit, the MCO may approve the request only if the Member or Medical Consenter agrees to pay any costs that are in excess of the service limit. The MCO must document the Member or Medical Consenter's agreement to pay these costs in the Member's file. Documentation must be on file prior to the MCO authorizing an adaptive aid that exceeds the service limit. Documentation must include, at a minimum:

- a description of the adaptive aid,
- rationale for exceeding the service limit,
- the cost incurred to the MCO,
- the cost incurred to the Member or Medical Consenter,
- the Member or Medical Consenter's signature,
- the date of the Member's agreement to pay costs that exceed the service limit, and
- signature of the Provider.

ii. Financial Management Services (FMS)

FMS is available for Members who choose the Consumer Directed Services (CDS) or Service Related Option (SRO). FMS provides assistance to Members with managing funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers.

iii. Flexible Family Support Services (FFSS)

FFSS are individualized and disability-related direct care services that help a Member participate in child care, post-secondary education, employment, independent living, or support a Member's move to an independent living situation.

FFSS include personal care supports for basic ADL and instrumental ADL, skilled task and delegated skilled task supports. FFSS promote community inclusion in typical child and youth activities through the enhancement of natural supports and systems and through recognition that these supports may vary by child, Provider, setting, and daily routine. FFSS may be delivered by the Home and Community Support Service Agency



MANUAL HHSC Uniform Managed Care Manual	CHAPTER 16.2	PAGE 6 of 60
CHAPTER TITLE STAR Health Medically Dependent Children Program (MDCP)	EFFECTIVE DATE December 10, 2016 Version 2.0	

(HCSSA) and also may be delivered by attendants or nurses employed through the CDS option. The provision of FFSS must be documented and retained in the Member's file. Documentation must include, at a minimum:

- a description of the type of service provided
- the number of units of service provided, and
- the ADLs, instrumental ADLs, skilled tasks, or delegated skilled tasks for which the Member is obtaining assistance.

FFSS in Child Care

The Member's Caregiver is responsible for basic child care either in or out of the Member's home. FFSS support the Member's participation in child care when the service provided by the child care does not support the Member's disability-related needs. If the Member's child care is not able to meet the Member's ADL, instrumental ADL, skilled task, non-skilled task, or delegated skilled task needs, the Service Manager may authorize FFSS.

FFSS may be used only when the Caregiver is working, attending school, or participating in job training, and are delivered in a setting where the delivery of similar supports is not already required or included as part of the service. For this reason, the Service Manager may not authorize FFSS during the same time period the individual receives PCS or CFC services. The Service Manager may not authorize FFSS during the Member's school hours in primary or secondary educational settings.

To determine the need for FFSS for participation in child care, the Service Manager must discuss with the Medical Consenter their plan for obtaining basic child care and whether it will be provided in or out of the Member's home or both. The delivery of FFSS does not include basic child care, which is watchful attention or supervision of the Member while the Caregiver is at work, in job training or at school. These remain responsibilities within the service delivered by the child care.

The Caregiver's cost for child care does not impact the Member's need for FFSS. The Service Manager must determine the amount of hours needed to support the Member's needs within the MDCP cost limit. The Service Manager should ask the Medical Consenter about the Member's personal and skilled task needs and the time needed to address those needs. The Service Manager should discuss the skill level required to assist the Member to address necessary safeguards that ensure the Member's health and welfare.

FFSS does not replace Personal Care Services (PCS) provided through Texas Health Steps or Community First Choice (CFC). FFSS are provided when a Member regularly



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	7 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

participates in child care in the home or out of the home, or participates in a community program or educational service. FFSS are authorized when, because of the child's condition or a change in the child's condition, their needs cannot be met. In these instances, additional care is required.

FFSS for Independent Living

A Member may indicate a desire for increased independence as he or she matures. If the Member needs assistance with ADL, instrumental ADL, skilled task, non-skilled task, or delegated skilled task needs, the Service Manager may authorize FFSS to help the Member with his or her goal for independent living.

To determine the need for FFSS for independent living, the Service Manager must discuss with the Member and Medical Consenter their plan for the Member's independent living arrangement. When identifying the Member's need for this service, the Service Manager should address age appropriateness for the tasks required to meet these needs. The Service Manager must determine the amount of FFSS needed to support the Member's needs. The Service Manager should discuss the skill level required to assist the Member and the appropriateness of the living arrangement and service delivery regarding the Member's age and health and welfare. FFSS may be used only when the Caregiver is working, attending school, or participating in job training.

FFSS in Post-Secondary Education

A Member can access FFSS to participate in post-secondary education. Post-secondary education institutions do not assist students with ADL, instrumental ADL, skilled task, non-skilled task, or delegated skilled task needs. If a Member has an ADL, instrumental ADL, skilled task, non-skilled task, or delegated skilled task need prohibiting the Member from participating in post-secondary education, the Service Manager may authorize FFSS so the Member may participate in post-secondary education.

To determine the need for FFSS in post-secondary education, the Service Manager must identify the Member's need for assistance and the amount of FFSS needed to support the Member's needs. The Service Manager should identify the Member's personal and skilled task needs and the amount of time needed to address those needs. The Service Manager should discuss with the Member or Medical Consenter the skill level required to assist the Member and address necessary safeguards to ensure the Member's health and welfare.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	8 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

iv. Minor Home Modifications

If a home modification is requested and the Member or Medical Consenter do not own the home in which the modification will take place, the Member, Medical Consenter, or Service Manager must obtain written agreement from the homeowner before a modification is authorized. A minor home modification must not create a new structure or add square footage to the home.

The minor home modification lifetime limit is \$7,500. The Service Manager may authorize up to \$300 per ISP period for maintenance or repairs of minor home modifications previously approved and reimbursed with waiver funds, or in the event that a request for repair or maintenance to a minor home modification is not covered by the Provider's warranty. The Service Manager does not include \$300 maintenance and repair limit as part of the \$7,500 lifetime limit. The amount paid for a minor home modification or for the repair of a minor home modification must be documented and retained in the Member's file.

The MCO may authorize bids for minor home modifications, as applicable. The cost of these bids do not count against the Member's lifetime limit for minor home modifications.

Minor home modifications are limited to:

- purchase and installation of permanent and portable ramps not covered by other sources;
- widening of doorways;
- modification of bathroom facilities; and
- modifications related to the approved installation or modification of ramps, doorways or bathroom facilities.

Minor home modifications must:

- adhere to Americans with Disabilities Act requirements;
- meet Texas Accessibility Standards;
- meet all applicable state and/or local building codes; and
- have a minimum one-year warranty.

Minor home modifications do not include the use of deluxe materials, such as granite, marble or high-end fixtures.

If the cost of a requested minor home modification exceeds the service limit, the MCO may approve the request only if the Member or Medical Consenter agrees to pay any costs that are in excess of the service limit. In the event that DFPS staff is listed as the



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	9 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

Medical consentor, the Caregiver who resides in or owns the home in which the modifications will occur must agree to the modification and payment for excess costs. The MCO must follow the procedures stated in subsection (i), Adaptive Aids, to document the Member or Medical Consentor's agreement. The provision of minor home modifications must be documented and retained in the Member's file. Documentation must include, at a minimum, a description of the type of home modification provided.

v. Respite

Respite services are direct care services needed because of a Member's disability that provide the Caregiver temporary relief from care giving activities when the Caregiver would usually perform such activities. Respite may not be delivered while the Member is in a school setting or during the time the Caregiver is at work, attending school, or in job training.

Because Respite is a service to provide relief to the Caregiver, if the Caregiver would normally be providing other services, Respite may be authorized at the same time. For example, a nurse may be providing PDN for the purpose of suctioning, monitoring vitals, etc., and an MDCP Respite attendant may be in the home at the same time providing PCS for the purpose of relieving the Caregiver of tasks they would normally be responsible for performing at that time. Circumstances which require two personnel for a two person transfer are not considered a duplication of services. In that scenario, the private duty nurse and MDCP Respite attendant could collaborate to accomplish the transfer.

The MCO may determine the number of units of Respite to authorize for an MDCP Member based on the Member or Caregiver's preferences and the Member's approved cost limit. MCOs may develop internal processes related to Respite service schedules, schedule changes, and policies regarding setting aside funds within the ISP.

In-Home Respite

In-home Respite may be delivered by a HCSSA, also called a home health agency, or delivered by attendants or nurses employed through the CDS option. In-home Respite is not limited to the Member or Caregiver's place of residence, but may also be provided in other community settings when the situation does not exceed the limitations documented in this section. Other community settings could include the park or the Respite provider's home. A Member's in-home Respite is limited by the amount of the Member's cost limit and available budget. MCOs may have additional policies and procedure regarding reserving capacity in a Member's budget. The provision of in-home



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	10 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

Respite must be documented and retained in the Member's file. Documentation must include, at a minimum, the number of units of service provided.

Out-of-Home Respite

Title 42 of the Code of Federal Regulations §441.301(b)(1)(ii) requires that MDCP services not be provided in an institution. However, Respite may be provided in a hospital or NF only if the sole reason for the Member's admission is Respite. For example, if a Member is admitted to a hospital for reasons such as illness, surgery, or stabilization/treatments, Respite must not be authorized concurrently. Facility-based Respite is limited to 29 days per ISP period. The 29-day limit applies to the total number of days a Member receives Respite in a hospital or NF.

The Member or Medical Consenter may request to exceed the 29-day facility-based Respite limit. Within five days of the request to exceed the 29-day limit, the MCO must review the Member's needs and the Caregiver's ability to meet those needs, and determine if the request falls within the Respite criteria. The MCO must ensure there is no danger to the Member's health and welfare.

vi. Employment Assistance (EA)

EA is assistance provided to a Member to help locate paid, competitive employment in the community and includes:

- identifying a Member's employment preferences, job skills, and requirements for a work setting and work conditions;
- locating prospective employers offering employment compatible with a Member's identified preferences, skills and requirements; and
- contacting a prospective employer on behalf of a Member and negotiating the Member's employment.

For any MDCP Member, the Service Manager must ensure and document that employment services are not available to the Member from the Member's school district or other available community resource before authorizing MDCP EA services.

The Service Manager must refer the Member to the Texas Workforce Commission (TWC) within 30 days of meeting with a Member and identifying an interest in obtaining employment. The Service Manager should contact the local TWC office to identify the referral process used by that office. Local TWC offices may be located at



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	11 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

<http://www.twc.state.tx.us/directory-workforcesolutions-offices-services-0#workforceServices>

A Member who has been referred for TWC or contacted TWC themselves is not eligible to receive EA through MDCP until TWC has developed the Individualized Plan of Employment (IPE) and the Member has signed it, or until the Member is denied services through TWC. If a Member refuses to contact TWC, he or she may not receive EA through MDCP. If a Member is denied assistance through TWC, EA through MDCP may be authorized.

If the Member has exhausted TWC services or was determined ineligible for TWC services, the Service Manager must authorize 10 hours for EA and document the service in the Member's file. EA may be authorized up to 180 days. The Member or Provider may request more hours for EA, if needed, and funds are available in the Member's MDCP budget.

Coordination with Texas Workforce Commission

Upon request and with proper authorization for disclosure, the Service Manager must assist the Member and provide the TWC Vocational Rehabilitation Counselor (VRC) with the Member's:

- photo identification;
- an original Social Security card;
- Member or Medical Consenter's home address and mailing address;
- names and addresses of any doctors the Member has seen recently;
- names and addresses of any schools the Member has attended;
- information about the Member's medical insurance;
- a list of places the Member has worked, including type of job, dates, the reason for leaving and salary;
- proof of income for the Member and his or her spouse;
- proof of expenses related to monthly mortgage/rental payments, debts imposed by court order, personal medical costs and other disability-related expenses;



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	12 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- names, addresses and phone numbers of two people who will always know how to contact the Member;
- any reports of recent medical exams, school records or other information that may help the VRC understand the Member's disability;
- Member's most recent healthcare service plan;
- any current vocational assessments or person-directed plans that focus on employment opportunities;
- any other available records pertaining to the Member's disabilities, including but not limited to medical, psychological and psychiatric reports;
- a copy of the Member's court-ordered guardianship documents, if any HHSC guardian has been appointed; and
- contact information for the Member's Service Manager.

If the VRC determines that TWC is not the appropriate resource to meet the Member's needs and does not take an application for services, documentation of this decision in the Member's file serves as sufficient evidence that TWC is not available and the Member is eligible to receive waiver-funded EA.

TWC will:

- notify the Member or Medical Consenter in writing if the Member is determined to be eligible, ineligible, or if TWC services are not available;
- notify the Member and Medical Consenter in writing when TWC services are completed;
- develop with the eligible Member and Medical Consenter an IPE within 90 days of determination of eligibility for services;
- begin coordinating the provision of services as identified on the IPE, once completed; and
- upon request and with proper authorization for disclosure and in compliance with HIPAA and other confidentiality laws, rules and regulations, provide copies of the Member's TWC records relating to the TWC application for services to the Service Manager, including:
 - a completed copy of the Member's application statement;
 - a Member's completed IPE;
 - written documentation specifying a Member's eligibility status; and



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	13 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- the notification letter indicating TWC services are completed.

If TWC has not notified the Member or Medical Consenter of an eligibility decision within 60 days of the initial TWC appointment, the Member's Service Manager will attempt to contact the assigned TWC VRC to determine the status of the application and document the contact in the Member's service manager's narrative notes.

The Member's Service Manager must ensure that communication is maintained between the assigned TWC VRC regarding waiver-funded EA services provided between the TWC Vocational Rehabilitation (VR) referral and the "start date" of TWC, as defined in the Member's TWC VR IPE. If the MCO has authorized the MDCP EA, and TWC EA is subsequently authorized, the Service Manager must close the waiver EA service on the date that TWC services are scheduled to begin. The Service Manager must include the TWC EA services as provision of a third party resource in the Member's HCSP.

At the request of a Member determined eligible for TWC, the Service Manager, if possible, will assist the Member and:

- participate in TWC planning meetings related to the Member's employment, or ensure
- ensure other individuals important to the Member attend, as appropriate;
- take an active role in providing input to the TWC IPE, or ensure other individuals important to the Member provide input, as appropriate; and
- review the LTSS listed on the TWC IPE and if any of those services and supports are available through the waiver, incorporate them in a revision to the Member's service plan prior to the end of TWC services.

The Member's Provider must begin providing or subcontracting for those services and supports approved in the Member's service plan without a gap between the provision of TWC and waiver services.

vii. Supported Employment

Supported Employment provides assistance to sustain paid, competitive employment to a Member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. Supported Employment services include employment adaptations, supervision, and training related to a Member's assessed need and ensuring Members earn at least minimum wage, if not self-employed.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	14 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

Competitive employment is work in the competitive labor market in which anyone may compete for employment that is performed on a full-time or part-time basis in an integrated setting and for which a Member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

An integrated setting is a setting typically found in the community in which Members interact with people without disabilities, other than service Providers, to the same extent that people without disabilities in comparable positions interact with other people without disabilities. An integrated setting does not include a setting in which groups of people with disabilities work in an area that is not part of the general workplace where people without disabilities work, or a mobile crew of people with disabilities who work in the community.

An MDCP Member may seek Supported Employment to provide assistance to the Member in maintaining self-employment. Self-employment is work in which the Member solely owns, manages and operates a business, is not an employee of another person, entity or business, and actively markets a service or product to potential customers.

Supported Employment may only be authorized through the MDCP waiver if documentation is maintained in the Member's file that the service is not available to the Member under a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. §1401 et seq.) or the TWC.

Coordination with the TWC

The Service Manager coordinates with the TWC and the local school districts, seeking third party resources before using MDCP employment services:

Activities include:

- devoting time during a Member's initial service planning meeting to discuss employment with the Member and Medical Consenter and the process to obtain employment services and supports;
- making a referral to TWC, assisting with completing the application form, and documenting the referral and outcome of the referral in the Member's file;
- continuing to explore the possibility of employment at subsequent service planning meetings for a Member who is not employed in the community;
- affirming or explaining how a Member can work and still maintain current medical benefits, and in most cases will have an increase in income;
- explaining rights to appeal if services are denied, reduced or terminated; and



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	15 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- monitoring whether the Member and Medical Consenter are satisfied with the employment supports.

viii. Transition Assistance Services (TAS)

TAS are a one-time service provided to a Medicaid-eligible resident of a NF located in Texas to assist the Member in moving from the NF into the community to receive MDCP services.

Children in conservatorship who are residing in a NF are excluded from enrollment in STAR Health, but may be enrolled in a STAR Kids MCO and receiving MDCP. If the placement in the community will result in the individual becoming eligible for STAR Health, the MCO must coordinate with DFPS staff, the TAS agency, and the individual's STAR Kids MCO to coordinate the relocation of an individual residing in a NF.

ix. FFSS or Respite Using an Attendant with Delegated Tasks

A delegated task is defined as a task that a physician or registered nurse (RN) delegates in accordance with state law. In general, the Texas Board of Nursing (BON) defines delegation as a nurse authorizing an unlicensed person to provide nursing services while retaining accountability for how the unlicensed person performs the task (See: 22 TAC §225.4). In brief, the Texas Occupations Code indicates a physician may delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate. Only an HCSSA nurse may delegate to an attendant under their supervision. A Member with a skilled task need may use an attendant with delegated tasks if a practitioner or RN delegates the skilled task required to meet the Member's needs.

If the Member does not have a skilled task need for the delivery of services, he or she does not have a need for an attendant with delegated tasks. If the Member or Medical Consenter requests the use of an attendant with delegated tasks, but the Service Manager or the HCSSA Provider determines the use of this Provider type places the individual's health and welfare at risk, the Service Manager should not authorize an attendant with delegated tasks, unless determined appropriate by the Member's physician.

If a Member or Medical Consenter employ an attendant under the CDS option, delegation of certain tasks is not required under the CDS option. Form 1585, Acknowledgment of Responsibility for Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services (CDS), outlines what services cannot be delegated, such as specific tasks involved in the implementation of the care



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	16 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

plan that require professional nursing judgment or intervention. If the Member or Medical Consenter are directing the Member's services, they must sign Form 1585, acknowledging responsibility for the training and oversight of an attendant.

C. MDCP Eligibility

STAR Health Members become eligible to be assessed for MDCP services when their name comes to the top of the MDCP interest list. Members are placed on the interest list on a first come-first served basis by contacting HHSC or their MCO. Once a Member comes to the top of the list, determination of eligibility begins as the Member applies for services.

To be eligible for services under the MDCP waiver, the Member must meet the following criteria:

- MN for a NF level of care;
- have an ISP with services under the established cost limit;
- have an unmet need for at least one monthly waiver service;
- be birth through age 20;
- be a United States citizen and Texas resident;
- be in an appropriate living situation; and
- have full Medicaid eligibility.

i. Medical Necessity (MN) Determination

A STAR Health Member must have a valid MN determination before admission into the MDCP waiver. The determination of MN is based on the completion of the Screening and Assessment Instrument (SAI). In the STAR Health Program, only the mandatory fields of the SAI must be completed in order to assess for MDCP services or other LTSS. Any further mention of the SAI means the mandatory fields of the SAI only.

The MCO must electronically submit the SAI to TMHP indicating a request for MN determination after obtaining a physician signature using Form 2601, Physician Certification. The SAI and Physician Certification must be retained in the Member's file.

Additional information about this process is available in Section V, Intake and Initial Application.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	17 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

ii. Individual Cost Limit

The cost of MDCP waiver services cannot exceed 50% of the cost of care the state would pay if the Member was served in a NF. For initial eligibility, the MDCP waiver applicant must have an ISP of MDCP services developed that is at or below 50% of the cost to provide services to the Member, based on their RUG in a NF.

For initial applications, the total cost of services for an applicant's MDCP services on Form 2604, Individual Service Plan must be equal to or below the individual's ISP cost limit. Applicants exceeding the cost limit cannot elect to receive reduced services for entry to the program if the reduced Medicaid state plan services and MDCP services would pose a risk to the individual's health, safety and welfare.

The Member's ISP cost limit is calculated based on information gathered through the SAI MDCP module. The MCO completes and submits the SAI to Texas Medicaid & Healthcare Partnership (TMHP). TMHP processes the SAI for Members to determine MN and calculate a Resource Utilization Group (RUG). A RUG is a measure of NF staffing intensity and is used in waiver programs to categorize needs for Members and establish the service plan cost limit.

iii. Unmet Need for at Least One Waiver Service

Pursuant to federal waiver requirements, individuals are not eligible to receive MDCP waiver services unless they have a need for at least one waiver service delivered monthly. For initial and continued eligibility for MDCP, a Member must have an unmet need for, and therefore use, at least one MDCP waiver service each month.

Therefore, a MDCP waiver ISP which has \$0.00 as the "Total Est. Waiver Cost" on Form 2604 will be rejected. Members who do not use at least one MDCP waiver service per month are subject to disenrollment from the waiver.

iv. Suitable Living Arrangement

The MCO must confirm that the Member, if under age 18, lives with a Medical Consenter or Caregiver in a community setting. STAR Health Members residing in a residential treatment center or other type of facility arrangement are not eligible to receive MDCP services under the waiver.

D. Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is a federal law that sets additional standards to protect the confidentiality of individually identifiable health information. Individually identifiable health information is



MANUAL	CHAPTER	PAGE
	16.2	18 of 60
CHAPTER TITLE		EFFECTIVE DATE
STAR Health Medically Dependent Children Program (MDCP)		December 10, 2016 Version 2.0

information that identifies or could be used to identify an individual and that relates to the:

- past, present or future physical or behavioral health or condition of the individual;
- provision of health care to the individual; or
- past, present or future payment for the provision of health care to the individual.

HHSC and MCO staff must send each member the Health and Human Services Agencies' Notice of Privacy Practices (links below), upon certification. This notice tells the Member about:

- his/her privacy rights;
- the duties of HHSC and the MCO to protect health information; and
- how HHSC and the MCO may use or disclose health information without his/her authorization. (Examples of use or disclosure include health care operations (for example, Medicaid), public health purposes, reporting victims of abuse, law enforcement purposes, sharing with HHSC/MCO contractors and coordinating government programs that provide benefits.

[Link to printable English PDF](#)

[Link to printable Spanish PDF](#)

i. Confidentiality and Handling of Records

Information collected in determining initial or continuing eligibility is confidential. The restriction on disclosing information is limited to information about individual Members. HHSC and the MCO may disclose general information about policies, procedures or other methods of determining eligibility, and any other information that is not about or does not specifically identify a Member. A Member, Medical Consenter, or Department of Family and Protective Services (DFPS) Caseworker may review all information in the case record and in HHSC or MCO handbooks that contributed to the decision about eligibility.

The MCO must keep all information that HHSC and the MCO have about a Member or any individual on the Member's case confidential. Confidential information includes, but is not limited to, individually identifiable health information. Before discussing or releasing information about a Member or any individual on the Member's case, the MCO must take steps to confirm the individual receiving the confidential information is either



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	19 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

the Member, Medical Consenter, or DFPS Caseworker, or someone else authorized to receive confidential information (for example, an attorney or personal representative).

Records must be safeguarded. The MCO must use reasonable diligence to protect and preserve records and to prevent disclosure of the information they contain, except as provided by HHSC and MCO regulations. Reasonable diligence for employees responsible for records includes keeping records:

- in a locked office when the building is closed;
- properly filed during office hours; and
- in the office at all times, except when authorized to remove or transfer them.

To dispose of documents with Member specific information, the MCO must follow procedures identified in the STAR Health Contract.

ii. Establishing Identity and Need

The MCO must establish the identity of attorneys or legal representatives by asking for the Member to provide Form 1826-D, Case Information Release, completed and signed by the Member or Medical Consenter. The MCO must maintain this documentation in the Member's file. HHSC staff must use established regional procedures to confirm the identity of legislators or their staff. The MCO must use established HHSC procedures to confirm the identity of legislators or their staff.

The MCO must establish the identity of an individual who presents themselves as a Member or Member's representative at an HHSC or MCO office by using sources such as a driver's license or 2085-B form. The MCO must establish the identity of state agency staff, federal agency staff, researchers or contractors by using an employee badge or government-issued identification card with a photograph.

The MCO must identify the need for agency staff, federal staff, research staff or contractors to access confidential information through official correspondence or a telephone call from a state or regional office, or contact with an HHSC attorney.

The MCO must contact appropriate regional or state office staff when state or federal agency staff, researchers, or contractors come to the MCO office without prior notification or adequate identification and request permission to access records.

If disclosing individually identifiable health information, the MCO must maintain documentation in the Member's case file regarding how the identity of the requestor was verified when contact is outside the interview.

Reasonable efforts must be made to limit the use, request or disclosure of individually identifiable health information to the minimum necessary to determine eligibility and



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	20 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

operate the MDCP program. The disclosure of individual medical information from HHSC MCO records must be limited to the minimum necessary to accomplish the requested disclosure. The Member or Medical Consenter authorizes the release of information by completing and signing Form 1826-D.

If the Member is an adult, listed as their own Medical Consenter, the Member may have a personal representative who has the authority to make health care decisions about the Member. This may include a person the Member has appointed under a medical power of attorney, a durable power of attorney with the authority to make health care decisions, or a power of attorney with the authority to make health care decisions, or a court-appointed guardian for the Member.

E. Member Rights and Responsibilities

Member rights and responsibilities are included in the Member Handbook. The required critical elements for the STAR Health Member Handbook are in Chapter 3.15 of the Uniform Managed Care Manual at: <http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/>.

A Member, Medical Consenter, or Caregiver may also refer to the Texas Administrative Code, Title 1 Administration, Part 15 Texas Health and Human Services Commission, Chapter 353 Medicaid Managed Care, Subchapter C Member Bill of Rights and Responsibilities to view the full list of Member rights and responsibilities. The Texas Administrative Code is available here: [http://texreg.sos.state.tx.us/public/readtac\\$ext.viewtac](http://texreg.sos.state.tx.us/public/readtac$ext.viewtac)

i. Correcting Information

A Member, Medical Consenter, or DFPS Caseworker has a right to correct any information that HHSC or the MCO has about the Member and any other individual on the Member's case.

A request for correction must be in writing and:

- identify the individual asking for the correction;
- identify the disputed information about the Member;
- state why the information is wrong;
- include any proof that shows the information is wrong;
- state what correction is requested; and



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	21 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- include a return address, telephone number or email address at which HHSC or the MCO can contact the individual.

If HHSC or the MCO agrees to change individually identifiable health information, the corrected information is added to the Member's file, but the incorrect information remains in the file with a note that the information was amended per the Member, Medical Consenter, or DFPS Caseworker's request.

The MCO must notify the requestor (the Member, Medical Consenter, or DFPS Caseworker) in writing within 60 days that the information is corrected, or will not be corrected, and the reason for the change. The MCO must inform the requestor if HHSC or the MCO needs to extend the 60-day period by an additional 30 days to complete the correction process or obtain additional information.

If HHSC or the MCO makes a correction to individually identifiable health information, the MCO must ask the Member, Medical Consenter, or DFPS Caseworker for permission before sharing with third parties. The MCO must make a reasonable effort to share the correct information with persons who received the incorrect information if they may have relied or could rely on it to the disadvantage of the Member.

The MCO must not follow the above procedures when the accuracy of information provided by a Member, Medical Consenter, or DFPS Caseworker is determined by another review process, such as a fair hearing or civil rights hearing. The decision in that review process to correct or not correct information must stand.

ii. Alternate Means of Communication

The MCO must accommodate a Member or Medical Consenter's reasonable requests to receive communications by alternative means or at alternate locations. The Member or Medical Consenter must specify in writing the alternate mailing address or means of contact, and include a statement specifying the reason for the request and whether the request was found to be reasonable.

F. Notifications

i. Program Support Unit (PSU) Notification Requirements

The PSU is responsible for preparing and sending notifications to the Member or Medical Consenter of actions taken regarding services and the right to a fair hearing. Form H2065-DSK, Notification of STAR Kids Managed Care Program Services, is the notice sent to a Member or Medical Consenter of the actions taken regarding MDCP



MANUAL HHSC Uniform Managed Care Manual	CHAPTER 16.2	PAGE 22 of 60
CHAPTER TITLE STAR Health Medically Dependent Children Program (MDCP)	EFFECTIVE DATE December 10, 2016 Version 2.0	

services. The form must be completed in plain language that can be understood by the Member or Medical Consenter. The language preference of the Member or Medical Consenter must be considered. Form H2065-DSK should be sent to the Member or Medical Consenter within two business days of the date a case is certified.

Form H2065-DSK is also used to notify an MDCP applicant who is denied MDCP waiver services or a Member whose MDCP services are terminated. The PSU must notify the MDCP applicant on Form H2065-DSK of the denial of application within two business days of the decision. See also Section VI, Denials and Terminations.

Notification forms must be posted to the MCO's STAR Health MDCP folder in TxMedCentral on the case action date. The PSU specialist's signature date on Form H2065-D is the case action date.

The MCO must use the following naming convention to post Form H2065-DSK to TxMedCentral:

Two-Digit Plan ID	Form #	Member ID, Medicaid # or SSN	Member Last Name (first four letters)	Section Number	Sequence Number of Form
##	2065	123456789	ABCD	D	2D or 2A

Denials will be coded with a "D" (denial) immediately following the form's sequence number. This denial file would be named ##_2065_123456789_ABCD_D_2D.doc.

Approvals will be coded with an "A" immediately following the sequence number. This approval file would be named ##_2065_123456789_ABCD_D_2A.doc.

ii. MCO Notification Requirements

The MCO is responsible for notifying the Member or Medical Consenter when an MDCP service is either denied or reduced. This is considered an adverse action and the Member or Medical Consenter has a right to appeal. Appeal rights of STAR Health Members can be found in the STAR Health Contract, **Section 8.1.5.9, "Member Complaint and Appeal Process"**.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	23 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

IV.SERVICE DELIVERY OPTIONS

Service Managers must present all service delivery options described in the STAR Health contract, **Section 8.1.40, Service Delivery Options**, to the Member or Medical Consenter at the initial assessment and each annual reassessment. MCOs must obtain a signature on Form 1584, Consumer Participation Choice, indicating the Member or Medical Consenter's choice of service delivery option. The MCO must keep Form 1584 in the Member's file. The MCO must ensure the Member or Medical Consenter understands he/she may request a service delivery option change at any time by contacting the MCO. If, at any time during the year, a current Member or Medical Consenter calls requesting information on service delivery options, the MCO must present the information to the Member or Medical Consenter.

The Member or Medical Consenter's decision to receive services using any of the service delivery options does not affect the Member's eligibility for services or the manner in which services are authorized.

A. Consumer Directed Services (CDS) Option

The Service Manager is responsible for offering the CDS option to all new STAR Health Members receiving applicable services, annually to current Members who are not enrolled in the CDS option, and whenever information is requested. The Service Manager:

- shares an overview of the benefits and responsibilities of the CDS option by reviewing Form 1581, Consumer Directed Services Option; and Form 1582, Consumer Directed Services Responsibilities;
- provides a copy of Form 1581 to the Member or Medical Consenter; and
- informs the Member or Medical Consenter of the right to choose service delivery through the agency option or the CDS option.

The Service Manager obtains the Member or Medical Consenter's signature on Form 1581 at the initial contact and signs and dates the form verifying the information was presented to the Member or Medical Consenter. A copy of Form 1581 is placed in the Member's file to document that CDS information was shared. At the annual reassessment, the Service Manager provides the Member or Medical Consenter with a copy of Form 1581 and clearly documents in the file that Form 1581 was shared with the Member or Medical Consenter.

When Members or Medical Consenters request information about the CDS option at other times, the Service Manager must provide CDS information to the Member or Medical Consenter within five business days after receipt of the request. The Service



MANUAL	CHAPTER	PAGE
	16.2	24 of 60
CHAPTER TITLE		EFFECTIVE DATE
STAR Health Medically Dependent Children Program (MDCP)		December 10, 2016 Version 2.0

Manager may provide the information by making a home visit or contacting the individual by telephone. If a home visit is not made, the Service Manager obtains the Member or Medical Consenter's signature by mailing Form 1581 to the Member or Medical Consenter with a postage-paid, return envelope. The Service Manager signs and dates Form 1581 indicating the information was presented. A signed copy of Form 1581 is placed in the Member's file to document Form 1581 was shared.

If the Member or Medical Consenter is still interested in participating in the CDS option once the information on Form 1581 is shared, the Service Manager reviews Form 1582 with the Member or Medical Consenter. The Service Manager:

- reviews with the Member or Medical Consenter the responsibilities, risks and advantages of the CDS option;
- assists the Member as needed in completing the individual self-assessment on Page 4 of Form 1582;
- obtains the Member or Medical Consenter's dated signature on Form 1582; and
- signs and dates Form 1582.

i. Initiating the CDS Option

Once a Member or Medical Consenter has chosen the CDS option, the Service Manager presents a list of contracted FMSAs. The Member or Medical Consenter must select an FMSA to perform CDS FMS. If the Member or Medical Consenter chooses the CDS option, the Service Manager proceeds to Form 1583, Employee Qualification Requirements, Form 1584, and Form 1586, Acknowledgement of Information Regarding Support Consultation Services in the CDS option. The Service Manager:

- provides Form 1583 to the Member or Medical Consenter, offering information on the additional responsibilities of being an employer in the CDS option and who may or may not be hired in the CDS option;
- shares Form 1584 with the Member or Medical Consenter, indicating their selection of the CDS option;
- provides Form 1586 to the Member or Medical Consenter, offering information about support consultation;
- obtains the Member or Medical Consenter's dated signature on Form 1583, Form 1584, Form 1586 if applicable; and
- signs and dates the forms.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	25 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

Within five business days of receipt of the completed Form 1584, Members or Medical Consenters who choose the CDS option are referred to the FMSA they selected to begin the CDS initiation process. The Service Manager provides the FMSA with Form 1584 and Form 1582.

The Service Manager must provide the FMSA with the authorized schedule of service delivery per day, week, month or other time frame specific to the service if not listed on the above forms.

Upon receipt of the CDS referral from the Service Manager, the FMSA completes the initial employer orientation with the Member or Medical Consenter in the Member's residence or setting of their choosing. The FMSA provides an overview of the CDS option, including the rules and requirements of applicable government agencies, and the roles of the employer and the FMSA. The Member or Medical Consenter signs and submits all required forms for participation in the CDS option and returns the forms to the FMSA within five calendar days after the date of initial orientation.

For Members or Medical Consenters new to CDS, following orientation, the Member or Medical Consenter and FMSA notify the Service Manager that CDS services are ready to begin, and the Service Manager negotiates a start date for services. The Service Manager revises the ISP and changes the appropriate CDS services authorizations to the FMSA. For ongoing Members, the ISP year remains the same. The same procedures are followed for any other transfer of agencies.

It is the responsibility of the Member or Medical Consenter and the FMSA to ensure that the expenditures for the year remain within the authorized amount. The MCO is responsible for timely payment of FMSA claims, submitted on behalf of the CDS employer, as well as for payment of the monthly service fee, from which the fees for the FMSA services come.

If the CDS employer is going to assume responsibility for training and supervising an unlicensed service provider to perform certain health related tasks, the FMSA assists the Member or Medical Consenter in completing the employer and employee acknowledgment.

The FMSA verifies potential service providers selected by the Member or Medical Consenter meet provider qualifications before the Member or Medical Consenter hires the service provider.

The FMSA must send a quarterly expenditure report to the Member or Medical Consenter and Service Manager and document and notify the MCO of issues or concerns, including:

- allegations of abuse, neglect, exploitation or fraud;



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	26 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- concerns about the Member's health, safety or welfare;
- non-delivery or extended breaks in services;
- noncompliance with employer responsibilities;
- noncompliance with service back-up plans; or
- over- or under-utilization of services or funds allocated in the Member's service plan for delivery of services to the Member through the CDS option and in accordance with the requirements of the STAR Health program.

The CDS employer is required to participate in the service planning meetings and provide requested documentation related to services and service delivery. The Member or Medical Consenter must provide documentation to support any requests for a revision to the ISP.

The FMSA may also participate in the Member's service planning if requested by the Member or Medical Consenter and if agreed to by the FMSA. The MCO and service planning team members, as appropriate, participate in approving back-up plans, developing corrective action plans, if necessary, and recommending suspension or termination of the CDS option.

ii. Service Planning for the CDS Option

The MCO must discuss with the Member or Medical Consenter the services delivered through CDS that are critical to the Member's health and welfare. The Member or Medical Consenter using the CDS option must have a back-up system to assure the provision of certain or critical authorized CDS services without a service break, even if there are unexpected changes in personnel. The Member or Medical Consenter must develop and receive approval from the Service Manager for each required service back-up plan, and document the plan on Form 1740, Service Backup Plan, in order to participate in the CDS option. The MCO must maintain a copy of Form 1740 in the Member's file.

The service back-up plan must list the steps the Member or Medical Consenter implements in the absence of the service Provider. The service back-up plan may include the use of alternate paid service Providers, unpaid service providers such as family members or friends., The MCO and service planning team, as appropriate, approve service back-up plans as being viable in the event a service provider is absent. The MCO or service planning team must approve each service back-up plan and any revision before implementation by the Member or Medical Consenter. The MCO



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	27 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

approves the service back-up plan by signing, dating and returning a copy of the plan to the Member or Medical Consenter. The Member or Medical Consenter is required to:

- budget sufficient funds in the CDS option budget to implement a service back-up plan;
- review and revise each service back-up plan annually;
- revise a service back-up plan if the Member experiences a problem in the implementation, or there are changes in availability of resources;
- redistribute funds that are not used in carrying out a service back-up plan; and
- provide a copy of the initial and revised service back-up plans and budgets to the FMSA within five business days after a plan's approval by the service planning team.

ii. Budgets

Members or Medical Consenters using the CDS option must develop an initial and annual budget and receive written approval from the FMSA before implementation of the budget and initiation of service delivery.

The FMSA must provide assistance as requested or needed by the Member or Medical Consenter to develop a budget. The FMSA reviews the budgeted payroll spending decisions, verifies the applicable budget workbooks are within the approved budget, and notifies the Member or Medical Consenter in writing of budget approval or disapproval. The FMSA must work with the Member or Medical Consenter to resolve issues that prevent the approval of budget plans.

The Member or Medical Consenter must submit budget revisions to the FMSA for approval. Revised budgets cannot be implemented until written approval is received from the FMSA. The FMSA must provide assistance to the Member or Medical Consenter with budget revisions as requested or needed, validate the budget, and provide written approval to the Member or Medical Consenter.

The MCO evaluates service plan changes requested by the Member or Medical Consenter and participates in the service planning team meetings to resolve issues when the Member or Medical Consenter does not follow the budget or comply with CDS option budget requirements.

The FMSA must assist a Member or Medical Consenter, as requested, to revise budgets to:



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	28 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- meet service back-up plan strategies approved by the Member's service planning team;
- reimburse documented, budgeted, allowable expenses incurred related to implementing service back-up plan strategies; and
- retain a copy of service back-up plans received from the Member or Medical Consenter.

v. Declining the CDS Option

If the Member or Medical Consenter declines or is not ready to select the CDS option at any point after Form 1581 is shared, the Service Manager:

- obtains the Member or Medical Consenter's signature on Form 1584 indicating his/her selection of the Agency Option; and
- signs and dates Form 1584.

The Service Manager must ensure the Member or Medical Consenter understands the CDS option is always available and that they may call the Service Manager to request a change to the CDS option at any time. However, the Member or Medical Consenter must wait 90 days before switching to a different service delivery option. Members or Medical Consenters who participate in the CDS option and choose to transfer back to the Agency Option will not have the choice of returning to the CDS option for at least 90 days. Service Managers must carefully coordinate transition activities when transitioning members to and from the CDS option.

B. Service Responsibility Option (SRO)

The MCO is responsible for ensuring the Member or Medical Consenter has an opportunity to make an informed choice by providing an objective and balanced review of the options, and monitoring the quality of services and service delivery.

Once the assessment is complete, the MCO is required to inform the Member or Medical Consenter about all options for managing services, and review Form 1582-SRO with the Member or Medical Consenter to determine if the SRO is an appropriate choice.

Form 1582-SRO, Service Responsibility Option Roles and Responsibilities, specifies the roles and responsibilities assigned to the Member or Medical Consenter, Provider and MCO. The Member or Medical Consenter, Provider, and MCO receive and sign Form 1582-SRO indicating their agreement to accept the SRO responsibilities.



MANUAL	CHAPTER	PAGE
	16.2	29 of 60
CHAPTER TITLE		EFFECTIVE DATE
STAR Health Medically Dependent Children Program (MDCP)		December 10, 2016 Version 2.0

In addition, the MCO's responsibilities include:

- presenting all service delivery options;
- documenting the Member or Medical Consenter's choice on Form 1584;
- explaining SRO rights, responsibilities and resources to the Member or Medical Consenter;
- presenting the MCO Provider list to the Member or Medical Consenter;
- making a referral to the Provider(s) selected;
- processing the Member or Medical Consenter's request to change service delivery options;
- redeveloping the service plan when a Member's needs change;
- serving as a resource if the Member or Medical Consenter has health or safety concerns, issues involving the attendant or other service-related concerns;
- convening a service planning team meeting in instances where the Member or Medical Consenter:
 - o has health and safety concerns;
 - o is having difficulty selecting or keeping an attendant; or
 - o has other issues relating to services that cannot otherwise be resolved; and
 - o monitoring services.

All monitoring for SRO Members is done by the MCO according to the mandated schedule for its specific services. When health and safety issues arise, the MCO staff:

- discuss the issues with the agency staff;
- talk to the Member or Medical Consenter to determine if the issues can be resolved; and
- convene a service planning team meeting if the issue cannot be resolved.

Because the Member or Medical Consenter now shares responsibility for service delivery, the MCO, in addition to other monitoring requirements, must monitor the Member or Medical Consenter's satisfaction with the SRO and ability to comply with SRO requirements. If it is evident that the Member or Medical Consenter is having difficulty in the management of SRO responsibilities, the MCO staff must consult the HCSSA staff; and advise the Member or Medical Consenter of the option to transfer back to the agency option.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	30 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

Members must be offered the SRO by the MCO annually, and may request a transfer to the SRO at any time. Additionally, the SRO must be presented to current Members or Medical Consenters at each annual reassessment or upon request. If the Member or Medical Consenter is interested in transferring to the SRO, they must sign Form 1582.

The MCO must ensure the Member or Medical Consenter understands the responsibility he/she is assuming. The MCO must:

- send Form H2067-MC, Managed Care Communication, to the HCSSA to advise it of the Member or Medical Consenter's selection;
- notify the HCSSA the Member or Medical Consenter will be contacting it for training;
- request the HCSSA to advise the MCO, using Form 2067-MC, when the transition planning is complete; and
- negotiate a start date with the Member or Medical Consenter and the HCSSA.

V. INTAKE AND INITIAL APPLICATION

A. Interest List Responsibilities for Initial Requests

STAR Health Members or Medical Consenters requesting MDCP services must be placed on the MDCP interest list according to the date and time of their request. Individuals are released from the interest list in order of the request date. MDCP does not set aside dedicated slots for children in DFPS conservatorship.

If the MCO staff receives a request for MDCP services, they must inform the Member or Medical Consenter about the MDCP interest list and refer the Member or Medical Consenter directly to the CSIL unit at 877-438-5658 for placement on the MDCP interest list.

The Member's name may only be added to the interest list if they are less than 21 years of age and reside in Texas.

i. Community Services Interest List (CSIL) Responsibilities



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	31 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

The HHSC CSIL unit manages the following activities related to the MDCP interest list:

- add and update individuals on the interest list;
- send an initial notification to the individual added to the interest list;
- perform annual contacts of individuals on the interest list for more than one year;
- release individuals from the interest list;
- confirm individuals in released status on the interest list are STAR Health Members by:
 - verifying the individual is listed on the provided spreadsheet of STAR Health Members on the interest list; and
 - identifying the Member has a current managed care segment indicating plan code 1E in the Texas Integrated Eligibility Redesign System (TIERS).
- provide a list of released individuals who are STAR Health Members, titled *MDCP Interest List Releases for STAR Health Members* to the designated Program Support Interest List (PSIL) email box for assignment to the appropriate Program Support Unit (PSU). The list of data elements will include:
 - Interest List Number
 - Assign to PSIL date
 - Name
 - Address
 - Contact phone numbers
 - County
 - Social Security Number
 - Medicaid Number

ii. PSIL Unit Responsibilities

The PSIL unit are HHSC staff responsible for coordinating and managing activities related to the release of an individual from the MDCP interest list.

Within **two business days** of receiving the names of STAR Health Member interest list releases from the CSIL unit, the PSIL unit must:



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	32 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- create a case in the HHS Enterprise Administrative Report and Tracking System (HEART);
- check TIERS for a current STAR Health enrollment segment (as shown by plan code 1E) and Medicaid type program to verify enrollment and determine if the Member is in DFPS conservatorship or has aged out of conservatorship (*reference charts below*);
- document the Member's current Medicaid status and MCO enrollment, if applicable, in HEART;
- assign the HEART case to the appropriate PSU staff to take all necessary case actions.

STAR Health Type Programs (TPs) -- Conservatorship

SAVERR TP	TIERS TP	COVERAGE
45	TP 45	Newborn children up to age one, born to Medicaid-eligible mothers
N/A	93	Foster Care – Federal Match – No Cash
N/A	94	Foster Care – Federal Match – With Cash
N/A	97	Foster Care – No Federal Match – No Cash
N/A	98	Foster Care – No Federal Match – With Cash

STAR Health Type Programs -- Aged Out

SAVERR TP	TIERS TP	COVERAGE
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MANUAL HHSC Uniform Managed Care Manual	CHAPTER 16.2	PAGE 33 of 60
CHAPTER TITLE STAR Health Medically Dependent Children Program (MDCP)	EFFECTIVE DATE December 10, 2016 Version 2.0	

SAVERR TP	TIERS TP	COVERAGE
	TP 70	Medical coverage for foster care youths age 18 – 21 who have aged out of foster care
	TA 82	Former Foster Care Children Ages 18-25 who have aged out of foster care
	TA 83	Former Foster Care Children - Presumptive

iii. Program Support Unit (PSU) Responsibilities

The PSU are regional HHSC staff responsible for facilitating the required components of the MDCP eligibility process by coordinating between HHSC, MCOs, and MDCP individuals.

Within **three business days** of the receipt of assignment, the PSU sends a request to the STAR Health MCO to receive current contact information for the Member's primary Medical Consenter, secondary Medical Consenter, and DFPS Caseworker. The STAR Health MCO must respond to these requests within **two business days**.

For STAR Health Members in Conservatorship:

Within **two business days** of receiving the current contact information from the STAR Health MCO, the PSU is responsible for the following activities:

- update the contact information in HEART; and
- contact the current primary Medical Consenter to confirm continued interest and give a general description of the MDCP services;
 - if contact is not made with the primary Medical Consenter, the PSU attempts to make contact with the secondary Medical Consenter or DFPS Caseworker;



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	34 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- the PSU ensures that the contact person, who may not be the person who applied for MDCP services on behalf of the Member, understands the MDCP benefits;
- if MDCP services are denied, the PSU **does not** remove the STAR Health Member from the MDCP interest list, and sends a notification of denial to the DFPS State Office Developmental Disability Specialist.

For STAR Health Members who have Aged Out (are age 18 or older):

The PSU is responsible for the following activities:

- update the contact information in HEART; and
- contact the current primary Medical Consenter, who should be the Member themselves, to confirm continued interest and give a general description of the MDCP services;
 - if contact is not made with the primary Medical Consenter, the PSU attempts to make contact with the secondary Medical Consenter, if indicated (there will not be a DFPS Caseworker);
 - the PSU ensures that the contact person, who may not be the person who applied for MDCP services on behalf of the Member, understands the MDCP benefits;
 - if MDCP services are denied by the Member, and the Member does not have a DFPS Caseworker or other Medical Consenter indicated, the PSU removes the Member from the interest list.

Within **three business days** of the receipt of assignment, PSU sends the following forms to the Member or Medical Consenter for completion:

- Form 2439, Selection Acknowledgement, to confirm interest in applying for MDCP services;
- MDCP information and frequently asked questions information sheet; and
- a postage-paid envelope.

If PSU staff are unable to contact the primary Medical Consenter, secondary Medical Consenter, or DFPS Caseworker (if indicated) by phone within **14 calendar days** from the date the enrollment packet was mailed, PSU must complete and mail Form 2442,



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	35 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

Notification of Interest List Release Closure, to the Member or Medical Consenter, and send a copy to DFPS State Office. Form 2442 must include the release date and release closure date, and must indicate that staff has not been able to contact the Member or Medical Consenter to begin the eligibility determination process. The release closure date is the **31st day** after the date on the release notification letter.

PSU must make one additional attempt to contact the primary Medical Consenter, secondary Medical Consenter, or DFPS Caseworker (if indicated) prior to the release closure date.

PSU should not attempt to contact a Member or Medical Consenter if HHSC receives information about the Member's death. The effective date of the release closure is the date staff received information of the Member's death. PSU must not send Form 2442 to the Member or Medical Consenter if the release was closed due to death of the Member.

- If PSU has not been able to contact the Member, primary or secondary Medical Consenter, or DFPS Caseworker within **31 days** from the date on the release notification letter, PSU must send a notification of unable to locate to the DFPS State Office Developmental Disability Specialist and follow the process and timelines described in **Section B, Declining MDCP Services**, below.

If applicable, within **three business days** after closing the release, PSU must upload Form 2442 and document the closure date and reason in HEART.

If the Member or Medical Consenter mails the packet into PSU within 90 days of the date of the closure letter, PSU will reopen the interest list case honoring the original request date. The Member will not be placed at the bottom of the interest list, PSU will proceed with processing the information provided.

B. Declining MDCP Services

i. For STAR Health Members in Conservatorship

If a Member or Medical Consenter completes and mails Form 2439, indicating no interest in applying for MDCP services or declines MDCP services before the release closure date, the PSU must notify the DFPS State Office Developmental Disability Specialist within **five business days** that a Medical Consenter has declined MDCP services on behalf of a child in DFPS conservatorship.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	36 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

The DFPS State Office Developmental Disability Specialist must respond to PSU within **five business days** to indicate:

- the Medical Consenter now agrees to accept MDCP services on behalf of the child, or
- DFPS agrees with the Medical Consenter that declining MDCP services is appropriate for the child and provides the reason for declining, or
- DFPS will escalate internally a continued refusal that may negatively impact the child.

If the PSU does not receive a response within five business days, the PSU will send one additional escalated notification to the DFPS Division Administrator for Placement and wait an additional **five business days** for a response.

If DFPS provides confirmation that the Medical Consenter will now accept MDCP services on behalf of the child, PSU must complete the following within **two business days** of receiving notice from DFPS:

- document the date confirmation was received from DFPS on the Medical Consenter's acceptance for MDCP services in HEART;
- verify the STAR Health MCO enrollment in TIERS; and
- complete Section A of Form H3676, Managed Care Pre-Enrollment Assessment Authorization and posts it to TxMedCentral.

If DFPS agrees with the Medical Consenter that declining MDCP services is appropriate for the child, PSU must close the release. The release closure date is the **31st day** after the date on the release notification letter. PSU staff must complete and mail Form 2442, informing the individual the release was closed due to being informed the individual no longer wishes to apply for MDCP services. The PSU must:

- upload Form 2442 and document the closure date and reason, and the date DFPS approved the choice to decline services in HEART; and
- document the closure date and reason in the CSIL database.

If DFPS must escalate internally a continued refusal of MDCP services that may negatively impact the child, PSU will hold open the release for an additional five business days to receive a final response from the DFPS State Office Developmental Disability Specialist.

ii. For STAR Health Members who have Aged Out (are age 18 or older)



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	37 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

If a Member who is no longer in DFPS conservatorship and is their own Medical Consenter completes and mails Form 2439 indicating no interest in applying for MDCP services or declines MDCP services before the release closure date the PSU must close the release. The release closure date is the **31st day** after the date on the release notification letter. Staff must complete and mail Form 2442, informing the Member the release was closed due to being informed the Member no longer wishes to apply for MDCP services. The PSU must:

- upload Form 2442 and document the closure date and reason in HEART; and
- document the closure date and reason in the CSIL database.

C. Receipt of Enrollment Packet

When the PSU receives the enrollment packet back from a Member or Medical Consenter, the PSU must review to ensure all documents are completed. If all documents are not completed, the PSU must contact the Member or Medical Consenter to obtain completed forms within **two business days** of receipt of the incomplete information.

Within **two business days** of receiving the enrollment packet or confirmed interest from the Member or Medical Consenter, the PSU must:

- verify the STAR Health MCO enrollment in TIERS;
- upload enrollment packet documents into HEART; and
- complete Section A of Form H3676 and upload to TxMedCentral.

D. Coordination of Assessments and ISPs

i. MCO Responsibilities

The STAR Health MCO has **30 calendar days** to complete all assessments for MDCP Members and submit required forms to the PSU. The MCO has an additional 30 calendar days to submit all required documentation, for a total of 60 calendar days following the initial notice from PSU. The MCO:

- verifies the individual meets all other eligibility criteria referenced in Section III, MDCP Overview and Eligibility;
- completes Section B of Form H3676;



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	38 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- completes the mandatory fields in the Screening and Assessment Instrument (SAI) tool, including Section R - MDCP Related Items; and
- completes Form 2604, ISP.

The MCO must schedule and complete the SAI, including the MDCP module, within **30 business days** of notice from PSU. Once the SAI and MDCP Module are complete, the MCO must submit the results from the SAI to the HHSC Administrative Services Contractor, Texas Medicaid & Healthcare Partnership (TMHP), within **72 clock hours** of completion. For the purposes of this requirement, an SAI is considered "complete" when the MCO has obtained the physician's signature using Form 2601, and has retained this form in the Member's case file.

TMHP processes the SAI for individuals to determine MN and calculate a Resource Utilization Group (RUG). A RUG is a measure of NF staffing intensity and is used in waiver programs to:

- categorize needs for individuals/Members; and
- establish the service plan cost limit.

When TMHP processes an SAI, the MCO will receive a substantive response file with a three-alphanumeric digit RUG. This code may also be viewed in the TMHP Long Term Care (LTC) online portal. An SAI with incomplete information will result with a BC1 code instead of a RUG value. An SAI resulting with a BC1 code does not have all of the information necessary for TMHP to accurately calculate a RUG for the Member. Code BC1 is not a valid RUG to determine MDCP eligibility.

The MCO must correct the information on the SAI within **14 calendar days** of submitting the assessment that resulted in a BC1 code. After **14 calendar days**, the MCO must inactivate the SAI and resubmit the assessment with correct information to TMHP. Information about the process of transmitting and correcting an SAI is available in Section VI, *Screening, Assessment, and Service Planning*.

The MDCP module of the SAI establishes an annual cost limit for each Member receiving MDCP services, which is based on the anticipated cost if the Member received services in a NF.

As a part of the ISP planning process, the MCO must establish an MDCP ISP that does not exceed the Member's cost limit. If the MCO does not properly establish this plan of care and the Member's ISP cost exceeds the individual limit, the MCO must continue to provide MDCP services at the MCO's expense through the end of the ISP year.

The MCO may not terminate MDCP enrollment if a Member's ISP exceeds the cost limit. The MCO must also adopt a methodology to track each Member's MDCP-related



MANUAL HHSC Uniform Managed Care Manual	CHAPTER 16.2	PAGE 39 of 60
CHAPTER TITLE STAR Health Medically Dependent Children Program (MDCP)	EFFECTIVE DATE December 10, 2016 Version 2.0	

expenditures on a monthly basis and provide an update on MDCP-related expenditures to the Member and Medical Consenter no less than once per month.

Service authorizations for MDCP must include the amount, frequency, and duration of each service to be provided, and the schedule for when services will be rendered. The MCO must ensure the MDCP Member does not experience gaps in authorizations and that authorizations are consistent with information in the Member's ISP.

All Members receiving MDCP services must be enrolled in Service Management. The plan of care for an MDCP Member must include the components of a person-centered service plan described in Title 42 of the Code of Federal Regulations § 441.301(c)(2), and must be incorporated into the Member's Healthcare Service Plan (HSP).

The MCO posts Form 2604 and Form H3676 to TxMedCentral in the MCO's STAR Health MDCP folder. If the MCO does not post an ISP within **60 calendar days** after the PSU posted Part A of Form H3676, the PSU notifies by email the health plan manager assigned to the MCO.

The MCO must use the following naming convention when posting the ISP to TxMedCentral:

Two-Digit Plan Identification (ID)	Form Number (#)	Member ID, Medicaid # or Social Security Number (SSN)	Member Last Name (first four letters)	Sequence Number of Form
##	2604	123456789	ABCD	2

This file would be named ##_2604_123456789_ABCD_2.doc.

The MCO must use the following naming convention when posting Form H3676 to TxMedCentral:

Two-Digit Plan ID	Form #	Member ID, Medicaid # or SSN	Member Last Name (first four letters)	Section Number	Sequence Number of Form
##	3676	123456789	ABCD	A	2

This file would be named ##_3676_123456789_ABCD_A_2.doc.

ii. PSU Responsibilities



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	40 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

Within **two business days** of receiving Form H3676 and the ISP, the PSU ensures the Member has:

- medical necessity;
- services under the established cost limits; and
- an unmet need for at least one waiver service.

The start of care (SOC) date for MDCP services is the first day of the month following receipt of the latter of the SAI or the ISP. The SOC date is the same as the ISP begin date, and **will always be the first day of the month**. Because Members are not eligible for any MDCP benefits between the Form H2065-DSK signature date and the ISP begin date, PSU specialists must record the correct date on the notification to the Member.

If eligibility is approved, within **two business days** of receiving the Form H3676 and Form 2604, PSU generates Form H2065-DSK, and:

- mails the original to the Member or Medical Consenter;
- posts the form on TxMedCentral in the MCO's STAR Health MDCP folder; and
- documents the closure date and reason in the CSIL database.

PSU must upload all applicable case forms to HEART.

If a Member fails to meet eligibility criteria for MDCP, within **two business days** of receiving the Form H3676 and Form 2604, PSU completes Form H2065-DSK and:

- mails the original to the individual;
- posts it on TxMedCentral in the MCO's STAR Health MDCP folder; and
- documents the closure date and reason in the CSIL database.

PSU must upload all applicable case forms to HEART.

E. Interest List Release Closures

The PSU must change the status of an interest list release in the CSIL database.

PSU will record the appropriate closure code in CSIL when a Member or Medical Consenter cannot complete the application process or when the Member or Medical Consenter receives an MDCP determination. Interest list closures are documented in HEART.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	41 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

i. Closing the Interest Release for an Applicant Choosing CLASS

When a Member or Medical Consenter is offered both MDCP and Community Living Assistance and Support Services (CLASS) and the Member or Medical Consenter chooses CLASS, PSU must notify the PSIL unit to close the MDCP release effective the date the PSU is notified of the decision to apply for CLASS. PSU notifies the PSIL unit by emailing the designated box MDCP_Interest_List@hhsc.state.tx.us. The email's subject line must read: **MDCP Closure**. The following elements must be included in the email:

- Member's name
- Interest List ID
- Program to be closed
- Date of closure
- Closure Reason

Within **two business days** of receiving notification of the Member's choice to apply for CLASS, PSU must mail Form 2442 to the Member or Medical Consenter. A copy of Form 2442 must be recorded in the Member's electronic case file in HEART. Once Form 2442 is sent to the CLASS individual, no follow-up contacts with the Member or Medical Consenter are necessary.

If the CLASS application is denied, Form 2442 instructs the Member or Medical Consenter to contact HHSC if he/she wishes to apply for MDCP. When the Member or Medical Consenter contacts HHSC, he/she will be reinstated on the MDCP interest list using the procedures stated below.

ii. Reopening an Interest List Closure

The PSU must submit a request to the PSIL unit to reopen a Member's closed interest list record for the following reasons:

- PSU staff were not able to contact the Member, Medical Consenter or DFPS staff before the release closure date.
- The Member or Medical Consenter received a dual offer (an offer to select one of two waiver slots), did not meet eligibility for the alternate waiver program, and wishes to apply for MDCP services.

Within three business days of receiving the request to apply for MDCP services, PSU staff must email a completed Form 2067-MC to the PSIL designated box and must include:

- the release date;



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	42 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- the release closure date;
- the reason for the closure; and
 - the reason for requesting to reopen a Member's closed CSIL record; or
 - a statement indicating that the application for an alternate waiver program was denied and the Member or Medical Consenter now wishes to apply for MDCP.

The PSIL unit will notify PSU of the outcome of the request. If an exception is granted, the PSU must contact the Member or Medical Consenter in order to begin the application process.

iii. Adding a Name Back to the Interest List

A Member's name may be added back to the CSIL after the name has been removed because staff are unable to locate the Member, Medical Consenter, or DFPS staff or because one of these parties failed to respond to attempted contacts.

A name is added back if the Member or Medical Consenter:

- contacts the PSIL within **90 calendar days** of the closure date and expresses continued interest, the name will be added back with the **original date** of request; or
- contacts the PSU more than **90 calendar days** following the closure date and expresses continued interest, the name will be added back with the **current date** as the request date.

Any exceptions for adding names back to the CSIL with the original date after a 90 day period must be approved by the HHSC Program Enrollment manager.

The earliest date a Member may be added back to the CSIL for the same program the Member is denied is the date the Member is determined to be ineligible for the program.

Example: The Member is released from the MDCP interest list on Aug. 2. The Member is denied eligibility for MDCP on Aug. 28, and a notification is sent to the Member or Medical Consenter of ineligibility. The first date the denied Member can be added back to the MDCP interest list is Aug. 28.

The earliest date a Member may be added back to the CSIL for the same program the Member is terminated is the first date the Member is no longer eligible for the program terminated.

Example: A Member's MDCP services are terminated July 31 due to denial of medical necessity. The first date the Member can be added back to the MDCP interest list is Aug. 1.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	43 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

VI. SCREENING, ASSESSMENT, AND SERVICE PLANNING

All MDCP recipients in the STAR Health program must receive an assessment, at least annually, using the Screening and Assessment Instrument (SAI). The MCO must assess each Member receiving MDCP services using the SAI at least annually or when the Member experiences a change in condition. The SAI also contains screening questions and modules that assess for medical, behavioral, and functional services. The MCO may use the SAI to assess Members for eligibility for services such as Community First Choice (CFC) and Personal Care Services (PCS).

A. Assessment of Medical Necessity

A determination of the level of care provided in a nursing facility (NF), or medical necessity (MN), is required for enrollment in MDCP and eligibility for CFC services. The MCO must complete the required fields for a determination of MN on the SAI and submit the assessment to TMHP for a determination of MN for a NF level of care.

Members coming off the MDCP interest list must be assessed for MN for eligibility for MDCP and the SAI must be completed no later than **30 calendar days** following notification from the PSU, as described in Section V, Intake and Initial Application. The MCO must submit the SAI to TMHP within **72 hours** of completion. For the purposes of submission, an SAI is only considered complete when the physician certification is on file. The MCO must complete the designated mandatory fields of the SAI, as specified in the SAI Document Map, including the fields required for MN and the MDCP Module. The MCO must indicate yes on Field Z5a (indicated by a "1") when seeking an MN determination from TMHP. A physician certification is required. Form 2601 must be maintained in the Member's file and must be obtained by the MCO and dated by the Member's physician prior to the submission of the SAI when Field Z5a is marked yes on initial assessments for MDCP.

If the MCO is assessing a Member for CFC services for the first time, in addition to the required fields for MN, the MCO must complete the functional assessment for CFC services using the personal care assessment module (PCAM), including Section P, as well as questions in Section Z that assess for support management and emergency response services. For a Member to continue to be eligible for CFC services, a determination of MN is required **every 12 months**. If a previous physician certification is in the Member's file, a new certification is not needed.

If a Member has had a determination of MN approval within the last 365 days, and either requests CFC services or comes off the interest list for MDCP services, the MCO



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	44 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

should leave Field Z5a as marked "no" (indicated by a "0") when completing and resubmitting the required portions of the SAI. The MCO must note when the Member's MN expires and arrange for a reassessment with the Member and Medical Consenter. A physician's certification is not required for a reassessment of MN.

Additional scenarios relating to MN determinations are available in the *MCO Business Rules for SK-SAI and SK-ISP*.

B. Member Reassessment of Medical Necessity

The MCO is responsible for tracking the renewal dates to ensure all Member reassessment activities are completed. Failure to complete and submit timely reassessments may result in the Member losing MDCP eligibility. Before the end date of the annual SAI, including applicable modules, the MCO must initiate an annual reassessment to determine and validate continued need for services for each Member. Reassessment must occur no earlier than 90 days before or **no later than 30 days** prior to the expiration date of the Member's current ISP on file. The MCO must indicate yes in Field Z5a to notify TMHP that an MN determination is required.

As part of the reassessment, the MCO must inform the Member or Medical Consenter about CDS and SRO. The MCO is expected to complete the same activities for each annual reassessment as required for the initial eligibility determination.

If the MCO determines the Member's health and support needs have not changed significantly within a calendar year of completing the SAI based on utilization records, Member reports, and provider input, the MCO may administer an abbreviated version of the SAI by pre-populating the instrument with information gathered during the previous assessment and confirming the accuracy of information with the Member or Medical Consenter. The MCO may not administer the abbreviated SAI more than once every other calendar year and may not administer the abbreviated SAI without previously completing the full SAI (mandatory fields only).

For Members requiring a reassessment of MN for a nursing facility level of care for continued eligibility for CFC or MDCP services, the MCO must administer the designated mandatory fields of the SAI and appropriate modules **no earlier than 90 days** before or **no later than 30 calendar days** prior to the expiration of the Member's current ISP on file. The MCO must indicate yes in Field Z5a to notify TMHP that an MN determination is required. Form 2601 is not required for reassessments of MN if the Member's file contains the form for a previous assessment. To ensure continuity of care, the MCO must ensure that the Member's reassessment for CFC and MDCP services, using the SAI and appropriate modules, is timed to prevent any lapse in service authorization or program eligibility.



MANUAL	CHAPTER	PAGE
	16.2	45 of 60
HHSC Uniform Managed Care Manual		
CHAPTER TITLE		EFFECTIVE DATE
STAR Health Medically Dependent Children Program (MDCP)		December 10, 2016
		Version 2.0

For Members receiving CFC services with a level of care for a psychiatric hospital or intermediate care facility for individuals with intellectual disabilities or related conditions (ICF/IIDs), the MCO must remind the Member or Medical Consenter to schedule a reassessment prior to the expiration of the Member's level of care assessment. The MCO must work with the mental health Provider assessing for Psychiatric Hospital level of care, or the Local Intellectual or Developmental Disability Authority (LIDDA), assessing for an ICF level of care.

C. Assessment and Reassessment for Personal Care Services (PCS)

For Members who receive PCS, the MCO may use the PCAM module of the SAI to assess for, and reassess annually for, the need for and amount and duration of PCS. The PCAM must also be completed at any time the Member experiences a placement change, when the MCO determines the Member may require a change in the number of authorized PCS hours, such as a change of condition or change in the available informal supports (e.g. changing school schedules), and upon Member or Medical Consenter request. The managed care organization must obtain a new physician statement of need to substantiate the Member's continued need for PCS upon each annual reassessment.

The following questions in the SAI Core Module are triggers for the PCAM and may indicate the Member requires PCS:

- a personal care aide is provided in a school or day program;
- the Member, Medical Consenter, or others are concerned about the Member's developmental status or decline from baseline related to self-care (dressing, bathing, using toilet self-care);
- decline in functional status as compared to 90 days ago or since last assessment;
- instrumental ADL or ADL self-performance;
- the Member is moderately or severely impaired regarding cognitive skills for daily decision making;
- the Member requires diet modification to swallow solid food;
- the Member requires modifications to swallow liquids;
- the Member received PCS, attendant care, or a home health aide in the last 30 days; and/or
- the Member or Medical Consenter requests an assessment for CFC or PCS.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	46 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

D. PSU Procedures for Reassessments

The PSU must ensure the Member's ISP is authorized annually. The PSU:

- checks TxMedCentral to determine if the MCO has submitted the ISP before the ISP end date;
- verifies the case has an approved SAI;
- verifies the ISP is within the cost limit; and
- takes a screenshot of the ISP, and posts the screenshot to HEART.

If the reassessment ISP is being submitted due to the Member's timely appeal of an MDCP waiver denial, staff enter the information from the old ISP, extending the end date an additional four calendar months. Services continue using this ISP until a decision is received from the hearing officer. At that time, changes are made, if necessary, to comply with the hearing officer's decision.

If the Member continues to meet waiver requirements, it is not necessary to send Form H2065-DSK, at the reassessment as notification of continuing services. If the Member does not meet waiver requirements, the PSU must, within two business days of notification:

- send Form H2065-DSK to the Member or Medical Consenter indicating why the case is being terminated; and
- terminate the ISP through the Long Term Care (LTC) Portal and generate Form H2065-DSK through the portal, if available. PSU posts Form H2067-MC to TxMedCentral to alert the MCO the denial notice is available in the LTC portal.

If the Member files an appeal timely, the PSU, within two business days of notification:

- posts Form H2067-MC in TxMedCentral to the MCO's STAR Health MDCP folder, using the appropriate naming convention, informing the MCO to continue services due to the timely appeal (if services have already ended, the MCO reinitiates services immediately); and
- extends the end date of the current ISP an additional four calendar months.

The MCO must use the following naming convention when posting forms to TxMedCentral:

An "M" or "S" is added to the sequence number to indicate whether the MCO or PSU posted the form.



MANUAL	CHAPTER	PAGE
	16.2	47 of 60
CHAPTER TITLE		EFFECTIVE DATE
STAR Health Medically Dependent Children Program (MDCP)		December 10, 2016 Version 2.0

Two-Digit Plan ID	Form #	Member ID, Medicaid # or SSN	Member Last Name (first four letters)	Sequence Number of Form
##	2067	123456789	ABCD	2M

This file would be named ##_2067_123456789_ABCD_2M.doc.

E. Service Planning

i. The ISP and Healthcare Service Plan (HCSP)

For STAR Health MDCP Members, the Healthcare Service Plan (HCSP) takes the place of Form H2603, STAR Kids Individual Service Plan (ISP) - Narrative Form.

The MCO Service Manager must work with the Member or Medical Consenter to create an ISP that includes MDCP services that do not exceed the Member's cost limit. Only MDCP services count toward the cost limit. The cost limit is based on the Member's RUG, which is determined based on the SAI. Cost limits associated with each RUG may be found at: <https://www.dads.state.tx.us/handbooks/cm-mdcp/appendix/l.htm>. The Service Manager documents these MDCP services in the HCSP.

The electronic ISP supplements the HCSP and contains a list of approved MDCP services. The list of MDCP services included in the HCSP must match the services submitted with the electronic ISP. For new MDCP Members coming off the interest list, the MCO completes and submits the electronic ISP **within 60 days** of the initial notification from the PSU. For all current MDCP Members, the MCO completes and submits the electronic ISP **within 60 days** following receipt of a response to the SAI submission.

When the Member's ISP is complete and within the Member's established cost limit, the MCO submits the ISP to TMHP. The MCO must submit the ISP prior to the start date of the Member's ISP.

An ISP is valid for one year. Each MDCP Member's ISP must be updated at least annually, or sooner in the following situations, within 14 calendar days of request or notification of a need or a change:

- following a significant change in health condition that impacts service needs;
- upon request from the Member or Medical Consenter;



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	48 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- at the recommendation of the Member's Primary Care Provider and/or health home; and
- following a change in life circumstance.

The Member's HCSP must be updated anytime the ISP is changed, and must include:

- a description of the recommended service needs identified through the SAI process;
- an MDCP plan of service that falls within the Member's allowable cost limit;
- covered services currently received;
- covered services not currently received, but that the Member might benefit from;
- a description of non-covered services that could benefit the Member;
- documentation of services received through third party sources, such as 1915(c) waivers operated by the state;
- the Member's goals and service preferences;
- natural strengths and supports available to the Member;
- special needs, requests, or considerations the MCO and/or Providers should know when supporting the Member;
- a description of roles and responsibilities for the Member, Medical Consenter, key service Providers, the MCO, and the Member's school, with respect to maintaining and maximizing the health and well-being of the Member;
- a plan for coordinating and integrating care between Providers and covered and non-covered services;
- short and long-term goals for the Member's health and well-being; and
- plans related to transitioning to adulthood, for Members age 15 and older.

The MCO is encouraged to request, but may not require the Member or Medical Consenter to provide a copy of the Member's Individualized Education Plan (IEP).

The MCO must list in the HCSP Medicaid state plan services the Member is receiving or is approved to receive, including service type, provider, hours per week (if applicable), begin/end date, and whether the Member has chosen the CDS or SRO (if applicable). The MCO must also include a brief rationale for the services. The MCO should also list services provided by third-party resources, like Medicare or available community services.



MANUAL	CHAPTER	PAGE
	16.2	49 of 60
CHAPTER TITLE		EFFECTIVE DATE
STAR Health Medically Dependent Children Program (MDCP)		December 10, 2016 Version 2.0

The MCO must provide a printed or electronic copy of the HCSP to each MDCP Member or Medical Consenter following any significant update and no less than annually within **five business days** of meeting with the Member or Medical Consenter. The MCO must provide a copy to the Member's Providers and ensure that the HCSP is available within the Member's Health Passport record. The MCO must write the HCSP in plain language that is clear to the Member or Medical Consenter and, if requested, must be furnished in Spanish or other language.

The MCO service manager is responsible for examining the HCSP and ISP for members receiving LTSS **no less than three days** prior to a face-to-face visit and for ensuring the document is up-to-date and adequately reflects the Member's current health, goals, preferences, and needs. The Member's service manager must review and update each Member's HCSP with the Member and Medical Consenter no less than annually during a face-to-face visit.

If a Member will turn 21 between the start and end date of the Member's ISP, the MCO should ensure any necessary adaptive aids, minor home modifications, or transition assistance are provided prior to the Member's birthday. If the MCO authorizes adaptive aids, minor home modifications, or transition assistance, the MCO remains responsible for payment for those services, including applicable warranties.

ii. Service Planning and Budget Revision

To revise a Member's MDCP ISP when there is no change in the Member's RUG, the MCO updates Form H2604 with the updated services and a revised begin date. The MCO maintains the updated Form H2604 in the Member's file.

To revise a Member's MDCP ISP when there may be a change to the Member's RUG, and thus their cost limit, the MCO must complete the mandatory fields of the SAI, including the MDCP module, and complete the following fields:

- A10c = Medicaid number of the individual
- A12 = 2 (Significant Change in Status Reassessment)
- Z5a = 0 (No)
- Z5b = 0 (No)

Following receipt of a response file indicating the Member's new RUG and associated cost limit, the MCO must complete a new ISP that reflects the Member and Medical Consenter's goals, preferences, and needs within the new cost limit. The MCO must subtract the cost of services provided under the original ISP and subtract that amount from the Member's new cost limit to assess available funds for the remainder of the ISP



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	50 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

period. The MCO must document how the available funds for the ISP period were determined and maintain documentation in the Member's file.

iii. Setting Aside Funds

MCOs may permit an MDCP Member or Medical Consenter to set aside MDCP funds, within the approved cost limit, for use later in the ISP period. If a Member or Medical Consenter choose to set aside funds, the MCO must use the MDCP Set Aside form to document the Member or Medical Consenter's preferences and maintain documentation in the Member's file. A Member or Medical Consenter may not carry forward funds between ISP periods.

If a placement change occurs, the MCO must track the set aside funds and communicate the balance of funds available to the Member or Medical Consenter at the next placement.

iv. Exceeding the Cost Limit

If the ISP cost exceeds 50 percent of the RUG cost limit, the MCO submits via email the following documents to the HHSC Utilization Review Transition/High Needs Coordinator:

- SAI
- ISP
- Medical records (nursing care plan, recent care notes, doctor's orders and nursing notes)
- Form H1024, Consumer Summary Report

HHSC Utilization Review may request a clinical review of the case to consider the use of State General Revenue funds to cover costs exceeding 50 percent of the RUG cost limit. If a clinical review is conducted, HHSC will provide a copy of the final determination letter to the MCO and the PSU.

Note: MCOs must not discuss this process with Members, or request use of State General Revenue funds for services above the cost ceiling.

v. Multiple MDCP Members in the Same Household

In some instances, multiple Members receiving MDCP services may live in the same household. In those instances, the STAR Health MCO is responsible for ensuring any



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	51 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

MDCP services for more than one Member in the same household delivered concurrently are provided in a way that protects the health and safety of each of those Members.

In such cases, the MCO may allow MDCP services to be provided in a Member to provider ratio other than one-to-one, as long as:

- each Member's care is based on his or her ISP and HCSP; and
- each client's needs are being met.

Example: Sarah and James's foster parents are scheduled to receive Respite services from 8am to 2pm every other Saturday. Sarah requires ventilator support, medication administration through a gastrostomy tube, and suctioning as needed. James requires assistance with ambulation, toileting, and eating. In this situation, the MCO should authorize the appropriate level of staffing to ensure that a Respite provider is able to appropriately see to Sarah's ventilator, medication, and suction without neglecting James' need for toileting and eating on a regular schedule.

vi. Suspension of MDCP Services

To remain eligible for MDCP services, a Member must receive one MDCP service monthly. In the event that the Member travels out of state, is admitted to a hospital or NF, or is unable to receive a waiver service in a particular month, the MCO must document the suspension of waiver services in the Member's case file. The MCO must document the dates during which services are suspended and the reason for the suspension.

A Member may not have services suspended longer than 90 days. If a Member's services are suspended 91 days or more, the MCO must notify the PSU using Form 2067-MC, and request closure of MDCP enrollment, following procedures in Section VII, Denials and Terminations.

vii. Budgeting for Aging Out Members

If the Member is turning 21 in less than one year, the ISP created for that year will be for less than twelve months. The MCO must prorate the Member's cost limit. To calculate the prorated cost, the MCO must:

- divide the cost limit by the total number of days in a year (365 days);
- determine the total number of days beginning with the start date of the ISP and ending with the date before the Member's 21st birthday; and



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	52 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- multiply the figure from Step 1 and the figure from Step 2 above to get the cost limit for the ISP period for which the Member is eligible.

Example: The Member's 21st birthday is July 9, and the ISP start date is April 1, and the end date will be on July 8. The Member's cost limit is \$25,000.

- Step 1: $\$25,000 \div 365 \text{ days} = \68.49 per day
- Step 2: The number of days per month: April = 30, May = 31, June = 30, July 1-8 = 8, for a total of 99 days.
- Step 3: $\$68.49 \times 99 = \$6,780.51$

\$6,780.51 is the prorated cost limit for the individual for the ISP.

F. Member Transfers

i. Transfers Between STAR Health and STAR Kids

A Member disenrolling from the STAR Health program due to exiting conservatorship may be eligible to continue their MDCP services through a STAR Kids MCO of their choice. In addition, a STAR Kids Member who enters conservatorship and begins enrollment in the STAR Health program may be eligible to continue their MDCP services through the STAR Health program.

To prevent duplication of activities when a program change occurs, the former, or "losing," MCO must provide the receiving, or "gaining," MCO with information concerning the results of the MCO's identification and assessment upon the gaining MCO's request. Within **five business days** of receiving the list of Members changing programs, the gaining MCO must request any documentation in the Member's case file from the losing MCO. The SAI and electronic ISP, as well as historical SAIs and ISPs, will be available to the gaining MCO upon enrollment through the TMHP Portal.

Within **five business days** of receiving the request, the losing MCO must provide the requested documents to the gaining MCO. The gaining MCO must ensure the Member's new Service Coordinator or Service Manager, once assigned, contacts the Member's former Service Coordinator or Service Manager at the losing MCO to ensure a seamless transition. If the gaining MCO experiences issues obtaining this information, they must notify HHSC HPM.

HPM must contact the losing MCO and require the MCO to upload information contained in the Member's file, and any current authorizations, within **two business**



MANUAL	CHAPTER	PAGE
	16.2	53 of 60
CHAPTER TITLE		EFFECTIVE DATE
STAR Health Medically Dependent Children Program (MDCP)		December 10, 2016 Version 2.0

days of notification. HPM informs PSU by email the date by which the MCO must upload the information to TxMedCentral. PSU transfers the information from the losing MCO to the gaining MCO within **two business days** of notification from HPM.

The STAR Health MCO, when gaining a Member already enrolled in MDCP, is responsible for service delivery from the first day of enrollment. Within **five business days** of receipt of notification on the 834 enrollment file, the MCO must contact the Member or Medical Consenter to discuss services needed by the Member. Within **15 business days** of receipt of notification on the 834 enrollment file, the MCO must conduct a home visit to assess the Member's needs and conduct a new SAI. For continuity of care, the visit may also include authorizations, additional assessments, and pending delivery of adaptive aids, minor home modifications, or transition assistance. The STAR Health MCO must adhere to all rules for SAI processing related to Member transfers outlined in the SAI business rules.

The STAR Health MCO must provide services and honor authorizations included in the prior ISP until the MCO is able to complete their own SAI, update the ISP, and issue new service authorizations. The MCO must allow the Member to continue to receive services with his or her existing Provider and allow an Out-Of-Network (OON) authorization to ensure the Member's condition remains stable and services are consistent to meet the Member's needs. Upon request, the MCO must immediately assist the Member or Medical Consenter in locating new Providers. OON authorizations must continue until the existing ISP expires or the MCO can provide comparable services by transitioning the Member to a Provider who will be able to meet the Member's complex needs.

ii. Transfers from another Waiver Program to MDCP

Members who are participating in other 1915(c) Medicaid waivers operated by the state may be on the interest list for MDCP. If a Member in another Medicaid waiver program comes up on the interest list for MDCP, a referral is made to the PSU.

PSU specialists are responsible for completing the following activities within **14 days** of the initial request for an MDCP assessment. All attempted contacts or encountered delays in reaching the Member, Medical Consenter, or DFPS staff must be documented. The PSU contacts the Member or Medical Consenter according to the procedures in Section III, Intake and Application applicable to a new STAR Health MDCP applicant.

PSU staff must coordinate with staff and Providers, as appropriate, to ensure the current 1915(c) Waiver services end the day before enrollment in MDCP.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	54 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

iii. Transfer from MDCP to another Waiver

STAR Health Members receiving MDCP services may be on an interest list for another Medicaid program such as Community Living and Support Services (CLASS) or Home and Community based Services (HCS). If HHSC informs the MCO that a Member receiving MDCP services has come to the top of the interest list for another program and is assessed as eligible for that program, the Service Manager must post form H2067-MC and communicate case information in the comments section of the form to assist the PSU in coordinating the end of MDCP services the day prior to the Member's enrollment in the new program. PSU must coordinate with the MCO about the end of MDCP services and the Member's transition to another waiver.

PSU specialists are responsible for completing the following activities within **14 days** of the initial request for an MDCP assessment. All attempted contacts or encountered delays in reaching the Member, Medical Consenter, or DFPS staff must be documented. The PSU:

- creates a case in HEART;
- checks the CSIL to see if the Member is on a 1915(c) interest list;
- confirms if the Member has an open enrollment with another 1915(c) waiver program according to the procedures below:
 - For either the Texas Home Living or HCS Waivers, check the Client Assignment and Registration (CARE) System, Screen 397 series, Client ID Information Screens, to verify whether a Member is enrolled in one of these programs. The screen specific to "waiver consumer assignment history" identifies enrollment, when applicable.
 - For the CLASS (Service Group 2) and Deaf Blind with Multiple Disabilities (Service Group 16) Waiver programs, check the Service Authorization System (SAS) to verify the service authorization record for these waivers:
- moves interest list with an "assessment requested" notation;
- closes the MDCP release in the CSIL system effective the date of the notification from the MCO informing of the Member's decision to transfer to another waiver program;
- sends Form 2442 to the Member or Medical Consenter notifying of the MDCP closure. If the CLASS or other waiver program application is denied, Form 2442 will instruct the Member or Medical Consenter to contact the CSIL if he/she wishes to apply for MDCP. When the Member or Medical Consenter contacts CSIL, he/she will be reinstated on the MDCP interest list.



MANUAL	CHAPTER	PAGE
	16.2	55 of 60
CHAPTER TITLE		EFFECTIVE DATE
STAR Health Medically Dependent Children Program (MDCP)		December 10, 2016 Version 2.0

G. Member Transition to Adult Programs

All STAR Health Members receiving MDCP services must begin receiving transition services when they are 15 years of age and periodically meet with a Transition Specialist to plan their transition to adulthood. Members who receive services from MDCP, Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Center (PPECC), CFC, or PCS and are transitioning to adult programs may apply for services through STAR+PLUS including, STAR+PLUS Home and Community Based Services (HCBS) Program, in order to continue receiving community-based services and avoid institutionalization. This transition can take place as early as the 1st of the month following their 21st birthday for Members in category 1 of the Target Population, and as late as the 1st of the month following their 22nd birthday for Members in category 2 of the Target Population.

Twelve months prior to the 21st birthday of a Member receiving services from MDCP, PDN, PPECC, or CFC, the STAR Health MCO must:

- identify all Members turning 21 within the next 12 months and schedule a face-to-face visit with the Member and Medical Consenter, and include the DFPS Caseworker and DADS guardian if applicable, to initiate the transition process; and
- address during the face-to-face visit with the Member and their supports overview of STAR+PLUS program, including STAR+PLUS HCBS and the changes that will take place when the Member transitions to STAR+PLUS. The following information must be provided:
 - the date at which STAR Health eligibility, MDCP, PDN, or any other services may terminate;
 - the array of services available in STAR+PLUS, STAR+PLUS HCBS, and HCS, and whether these programs may be an option available to the Member;
 - the date at which transition activities will begin;
 - assistance in finding an adult PCP, specialists, and dentist;
 - referrals to community organizations that may provide important supports to the Member (such as federal, state, county, and city social service agencies, civic and religious organizations, consumer groups, advocates, and councils);



MANUAL	CHAPTER	PAGE
	16.2	56 of 60
CHAPTER TITLE		EFFECTIVE DATE
STAR Health Medically Dependent Children Program (MDCP)		December 10, 2016 Version 2.0

- coordination of visits to potential community living options;
- the importance of choosing a STAR+PLUS MCO six months before the transition occurs in order to avoid being assigned an MCO or having a gap in services;
- the Member, Medical Consenter, or guardian can change MCOs any time after the first month of enrollment; and
- an overview of the STAR+PLUS eligibility, assessment, ISP, and cost limit processes.
- notify the Utilization Review Transition/High Needs Coordinator by email if the Member:
 - is on ventilator care; and/or
 - the individual has high-skilled nursing needs, such as tracheotomy care, wound care, suctioning or feeding tubes.

Twelve months prior to the 21st birthday of a Member receiving PCS, the Health MCO must:

- identify all Members turning 21 and receiving PCS only within the next 12-months and schedule a face-to-face visit with the Member and Medical Consenter, and include the DFPS Caseworker and DADS guardian if applicable, to initiate the transition process;
- address during the face-to-face visit with the Member and their supports, the STAR+PLUS program, including STAR+PLUS HCBS and the changes that will take place when the Member transitions to STAR+PLUS. The points to be discussed are as follows:
 - the date at which STAR Health eligibility, MDCP, PDN, or any other services may terminate;
 - the array of services available in STAR+PLUS, STAR+PLUS HCBS, and 1915 (c) waivers, and whether these programs may be an option available to the Member;
 - the HHSC Enrollment Broker will reach out to the Member and Medical Consenter 30-days prior to the individuals 21st birthday and provide the Member and Medical Consenter with a STAR+PLUS enrollment packet and MCO list); and
 - the MCO selection process.

The Transition/High Needs Coordinator must:



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	57 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- monitor the STAR Health deliverables required by UCMCM Chapter 5.4.5, LTSS Utilization Reports, and identify all Members turning 21 in 12 months and not enrolled in one of the following IDD 1915 (c) waivers:
 - Community Living Assistance and Support Services (CLASS);
 - Deaf Blind and Multiple Disabilities (DBMD);
 - Home and Community-based Services (HCS); and
 - Texas Home Living (TxHmL); and
- coordinates with the Utilization Review staff for the IDD waivers and the PSU if it is determined the individual is high needs and/or will need to be assessed for STAR+PLUS.

VII. DENIALS AND TERMINATIONS

The MCO must adhere to 42 Code of Federal Regulations (CFR) Part 431, Subpart E, which governs fair hearing rights for Medicaid applicants and beneficiaries. In addition, Title 1 of the Texas Administrative Code (TAC) §353.1209, which is cited on Form H2065-DSK, Notification of STAR+PLUS Program Services, is the basis for all case actions.

A. Medical Necessity (MN)

MDCP waiver services must be denied/terminated when the Member's MN is denied. Within two business days, the PSU staff must:

- send the Member or Medical Consenter Form H2065-DSK;
- post the form on TxMedCentral in the MCO's STAR Health MDCP folder; and
- upload Form H2065-DSK to HEART.

Notification can come from:

- the Monthly ISP Expiring Report;
- Enrollment Resolution Services (ERS);
- the MCO; or
- other reliable sources.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	58 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

The MN status of "MN Denied" in the Long-term Care (LTC) Portal is the period when the MDCP Member's physician has 14 calendar days to submit additional information. Once an SAI MN status is in "MN Denied" status, several actions may occur:

- MN Approved: The status changes to "MN Approved" if the TMHP doctor overturns the denial because additional information is received;
- Overturn Doctor Review Expired: The status changes to "Overturn Doctor Review Expired" when the 14 calendar day period for the TMHP doctor to overturn the denied
- MN has expired. No additional information was submitted for the doctor review. The denied MN remains in this status unless a fair hearing is requested; or
- Doctor Overturn Denied: The status changes to "Doctor Overturn Denied" when additional information is received but the TMHP doctor does not believe the information submitted is sufficient to approve an MN. The denied MN remains in this status unless a fair hearing is requested.

The PSU specialist must not mail Form H2065-DSK to deny the MDCP waiver case until after 14 calendar days from the date the "MN Denied" status appears in the LTC Portal. The PSU specialist must meet initial certification and annual assessment time frames unless the time frames cannot be met due to the pending MN status. All delays must be documented.

B. Death of a Member

Upon learning of the death of a Member, the PSU must post Form H2067-MC to the MCO via TxMedCentral within two business days of verification. PSU does not send a notice to the Member or Medical Consenter's address. The effective date is the date of death. PSU staff upload Form H2067-MC to HEART.

C. Member or Medical Consenter Request

When the PSU has been notified a Member or Medical Consenter no longer wants waiver services, within two business days of receiving notification, PSU must:

- confirm that DFPS staff are in agreement that the Member should no longer receive MDCP services;
- if confirmation is received, send the Member or Medical Consenter Form H2065-DSK;
- post the form on TxMedCentral in the MCO's STAR Health MDCP folder; and



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	59 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

- upload Form H2065-DSK to HEART.

D. Unable to Locate

MDCP waiver services should never be denied/terminated for a STAR Health Member due to an inability to locate the Member. The PSU staff must:

- contact the MCO to receive the current primary and secondary Medical Consenter and DFPS Caseworker contact information; and
- if PSU still is unable to locate the Member, Medical Consenter, or Caseworker, notify DFPS state office staff that assistance is required in obtaining a response from the Member or Medical Consenter to initiate or continue MDCP services.

E. Other Citation Types

Use the denial citation "failure to meet other waiver requirement" if the Member does not meet a waiver requirement mentioned in Section III, MDCP Overview and Eligibility. For example, this citation would be used if the Member applying for services does not require at least one waiver service. Within two business days, the PSU staff must take the steps listed in subsection (i), Medical Necessity, above.

Notification can come from:

- monthly reports;
- Enrollment Resolution Services (ERS);
- the MCO; or
- other reliable sources.

F. Exceeding the Cost Limit

The MCO must consider all available support systems in determining if the waiver is a feasible alternative that ensures the needs of the Member are adequately met. If the waiver is not a feasible alternative, the MCO must notify the PSU of the denial and maintain appropriate documentation to support the denial. The MCO's documentation of this type of denial is based on the inadequacy of the plan of care, including both waiver and non-waiver services, to meet the needs of the Member within the cost limit.

If the ISP is over the cost limit, within two business days of receipt of the ISP, the PSU staff must take the steps listed in subsection (i), Medical Necessity, above.



MANUAL	CHAPTER	PAGE
HHSC Uniform Managed Care Manual	16.2	60 of 60
CHAPTER TITLE	EFFECTIVE DATE	
STAR Health Medically Dependent Children Program (MDCP)	December 10, 2016	
	Version 2.0	

G. Failure to Comply with Mandatory Program Requirements and Service Delivery Provisions

If the Member or Medical Consenter repeatedly and directly, or knowingly and passively, condones the behavior of someone in his home and thus refuses more than three times to comply with service delivery provisions, services may be denied/terminated. Refusal to comply with service delivery provisions includes actions by the Member or someone in the Member's home that prevent determining eligibility, carrying out the service plan, or monitoring services.

The MCO must immediately report unresolved instances of failure of a Medical Consenter to comply with mandatory program requirements and service delivery provisions that may jeopardize the Member's eligibility for MDCP services to the DFPS State Office Developmental Disability Staff and the DFPS Division Administrator for Placement. Upon notification of instances of non-compliance, this DFPS Staff will coordinate with responsible parties to resolve the issue in order to avoid termination of MDCP services for the Member.

If DFPS is unable to resolve the issue within **two business days** of the notification, the PSU staff must take the steps listed in subsection (i), Medical Necessity, above.